Alaska Department of Health and Social Services
Office of Children's Services

Health History

This form is to be completed by persons applying to be a resource family.
This information will be used for the sole purpose of foster care, adoption, or guardianship.

Full Name: _____ Date of Birth: _____

Applicant History:

Name and Title of Physician or Practitioner: _____

Physician or Practitioner Address: _____

1. Do you have any physical limitations that may impact your ability to parent a child with special needs? ☐ Yes ☐ No
   If yes, please explain:

2. Do you have difficulty walking or lifting? ☐ Yes ☐ No

3. Are your hearing, speech, or vision impaired? ☐ Yes ☐ No
   If yes, please explain:

4. Are you currently in treatment for a physical condition? ☐ Yes ☐ No
   If yes, please explain and give name, address, and phone number of physician or practitioner

5. Are any household members currently in counseling? ☐ Yes ☐ No
   If yes, please explain and give name, address, and phone number of counselor:

6. Have you currently or in the past been treated for any mental illness? ☐ Yes ☐ No

7. Have you had any recent surgeries or hospitalizations within the last year? ☐ Yes ☐ No
   If yes, please list:

8. Have any medications been prescribed during the past five years for ongoing medical and/or psychological conditions? ☐ Yes ☐ No
   If yes, please describe:

9. Are you currently taking any prescription or "over the counter" medications? ☐ Yes ☐ No
   If yes, please list:

10. Do you drink alcohol? ☐ Yes ☐ No
    If yes, please list frequency and amounts consumed:

11. Have you ever had treatment for use of alcohol ☐ Yes ☐ No

12. Do you use tobacco? ☐ Yes ☐ No
    If yes, for how long, what kind, and how much?

13. Do you smoke indoors? ☐ Yes ☐ No

14. Have you used any illegal drugs within the last 5 years? ☐ Yes ☐ No
    If yes, please explain:

15. Have you ever had treatment for use of illegal drugs? ☐ Yes ☐ No

Applicant Name: _____

Medical History

Have you ever experienced, been treated for, or has treatment ever been recommended for the following? (Please check any that are applicable and list any past or present treatment)

- ☐ Anxiety, panic attacks, depression
- ☐ Asthma
- ☐ Bladder disorder
- ☐ Cancer
- ☐ Cerebral palsy
- ☐ Chronic bronchitis
- ☐ Colitis
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy (seizures)
- ☐ Head injuries
- ☐ Fainting spells
- ☐ Heart disease
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ HIV/AIDS
- ☐ Hypoglycemia
- ☐ Kidney disorder
- ☐ Muscular/skeletal disorders (i.e., arthritis, lupus, bursitis, disc problems, multiple sclerosis, muscular dystrophy, spinal injuries, joint injuries, etc.)
- ☐ Prostate disorder
- ☐ Psychiatric, emotional, or other mental health disorder
- ☐ Stroke
- ☐ Thyroid conditions
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Other:

Please explain any boxes checked:

Signature _____ Date _____